

CERTIFICATE OF MEDICAL NECESSITY			DMERC 07.02A
SEAT LIFT MECHANISM			
SECTION A		CERTIFICATION TYPE/DATE: INITIAL <u> </u> / <u> </u> / <u> </u> REVISED <u> </u> / <u> </u> / <u> </u>	
PATENT NAME, ADDRESS, TELEPHONE AND HIC NUMBER		SUPPLIER NAME, ADDRESS, TELEPHONE AND NSC NUMBER	
() <u> </u> HICN <u> </u>		() <u> </u> NSC# <u> </u>	
PLACE OF SERVICE <u> </u> NAME AND ADDRESS OF FACULTY IF APPLICABLE (SEE REVERSE)	HCPCS CODE <u> </u> <u> </u> <u> </u>	PT DOB <u> </u> / <u> </u> / <u> </u> ; SEX(M/F); HT <u> </u> (IN.); WT <u> </u> (LBS.)	
		PHYSICIAN NAME, ADDRESS (PRINTED OR TYPED)	
		PHYSICIAN'S UPIN: <u> </u> PHYSICIAN'S TELEPHONE #: () <u> </u>	
SECTION B INFORMATION IN THIS SECTION MAY NOT BE COMPLETED BY THE SUPPLIER OF THE ITEMS/SUPPLIES.			
EST. LENGTH OF NEED (# OF MONTHS): <u> </u> 1-99 (99=LIFETIME)		DIAGNOSIS CODES (ICD-9): <u> </u> <u> </u> <u> </u>	
ANSWERS	ANSWER QUESTIONS 1-5 FOR SEAT LIFT MECHANISM (CIRCLE Y FOR YES, N FOR NO, OR D FOR DOES NOT APPLY)		
Y N D	1. DOES THE PATIENT HAVE SEVERE ARTHRITIS OF THE HIP OR KNEE?		
Y N D	2. DOES THE PATIENT HAVE A SEVERE NEUROMUSCULAR DISEASE?		
Y N D	3. IS THE PATIENT COMPLETELY INCAPABLE OF STANDING UP FROM A REGULAR ARMCHAIR OR ANY CHAIR IN HIS/HER HOME?		
Y N D	4. ONCE STANDING, DOES THE PATIENT HAVE THE ABILITY TO AMBULATE?		
Y N D	5. HAVE ALL APPROPRIATE THERAPEUTIC MODALITIES TO ENABLE THE PATIENT TO TRANSFER FROM A CHAIR TO A STANDING POSITION (E.G., MEDICATION, PHYSICAL THERAPY) BEEN TRIED AND FAILED? IF YES, THIS IS DOCUMENTED IN THE PATIENT'S MEDICAL RECORDS.		
NAME OF PERSON ANSWERING SECTION B QUESTIONS. IF OTHER THAN PHYSICIAN (PLEASE PRINT): NAME: <u> </u> TITLE: <u> </u> EMPLOYER: <u> </u>			
SECTION C		NARRATIVE DESCRIPTION OF EQUIPMENT AND COST	
(1) NARRATIVE DESCRIPTION OF ALL ITEMS, ACCESSORIES AND OPTIONS ORDERED; (2) SUPPLIER'S CHARGE; AND (3) MEDICARE FEE SCHEDULE ALLOWANCE FOR EACH ITEM, ACCESSORY, AND OPTION. (SEE INSTRUCTIONS ON BACK)			
SECTION D		PHYSICIAN ATTESTATION AND SIGNATURE/DATE	
I CERTIFY THAT I AM THE PHYSICIAN IDENTIFIED IN SECTION A OF THIS FORM. I HAVE RECEIVED SECTIONS A, B AND C OF THE CERTIFICATE OF MEDICAL NECESSITY (INCLUDING CHARGES FOR ITEMS ORDERED). ANY STATEMENT ON MY LETTERHEAD ATTACHED HERETO, HAS BEEN REVIEWED AND SIGNED BY ME. I CERTIFY THAT THE MEDICAL NECESSITY INFORMATION IN SECTION B IS TRUE, ACCURATE AND COMPLETE, TO THE BEST OF MY KNOWLEDGE AND I UNDERSTAND THAT ANY FALSIFICATION, EMISSION, OR CONCEALMENT OF MATERIAL FACT IN THAT SECTION MAY SUBJECT ME TO CIVIL OR CRIMINAL LIABILITY.			
PHYSICIAN'S SIGNATURE <u> </u>		DATE <u> </u> / <u> </u> / <u> </u> (SIGNATURE AND DATE STAMPS ARE NOT ACCEPTABLE)	

FIG. 1

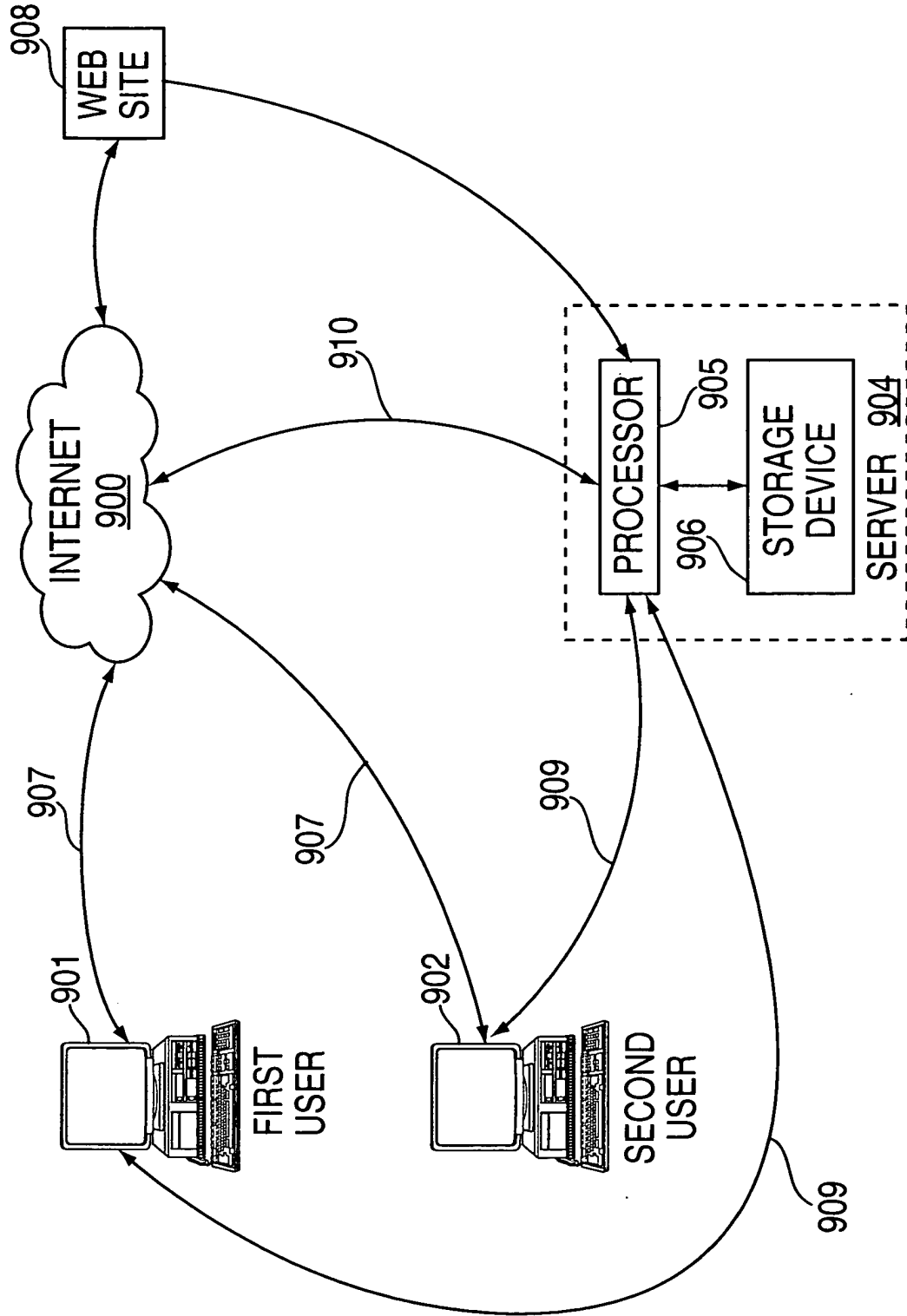


FIG. 2

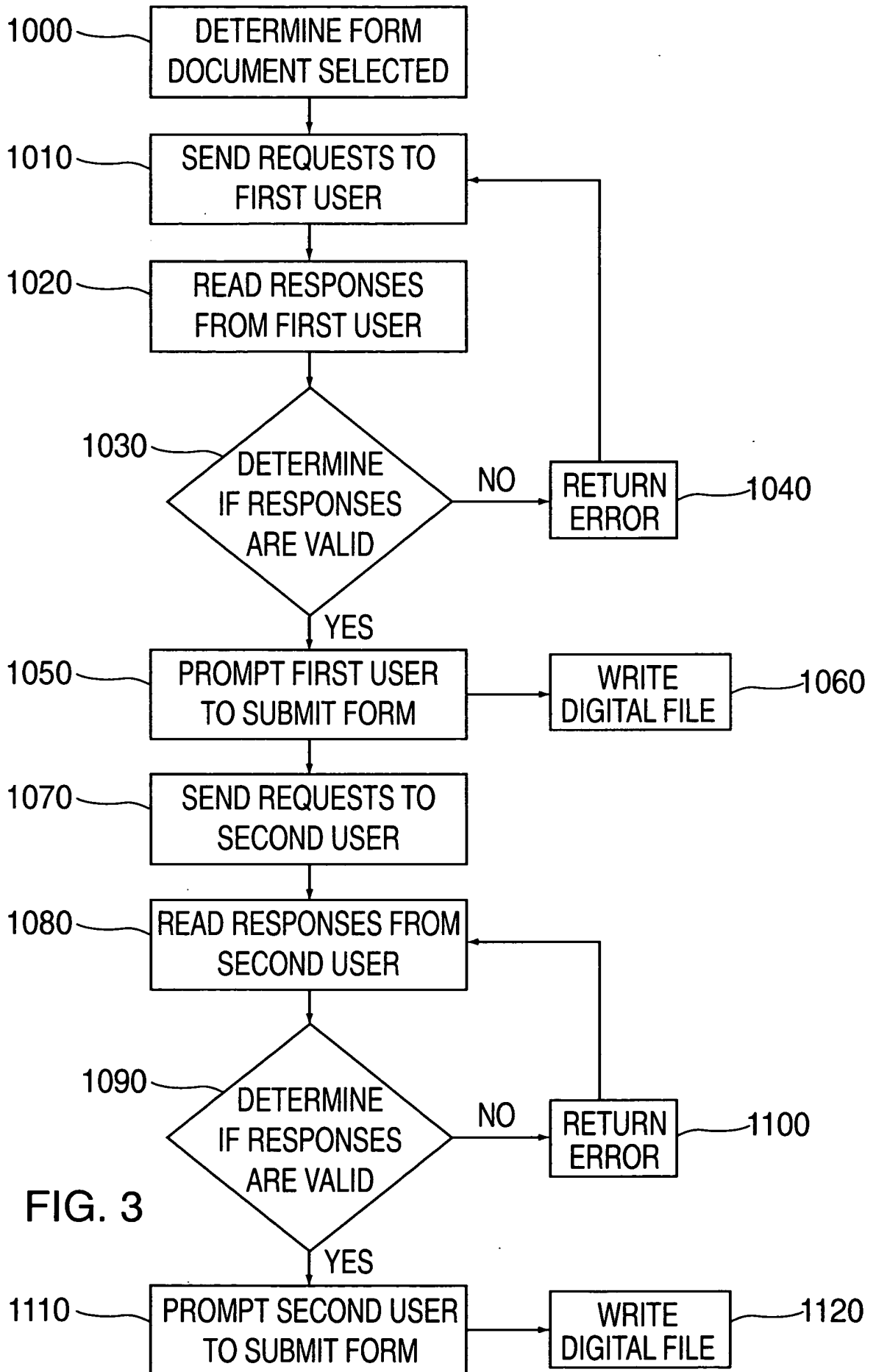


FIG. 3

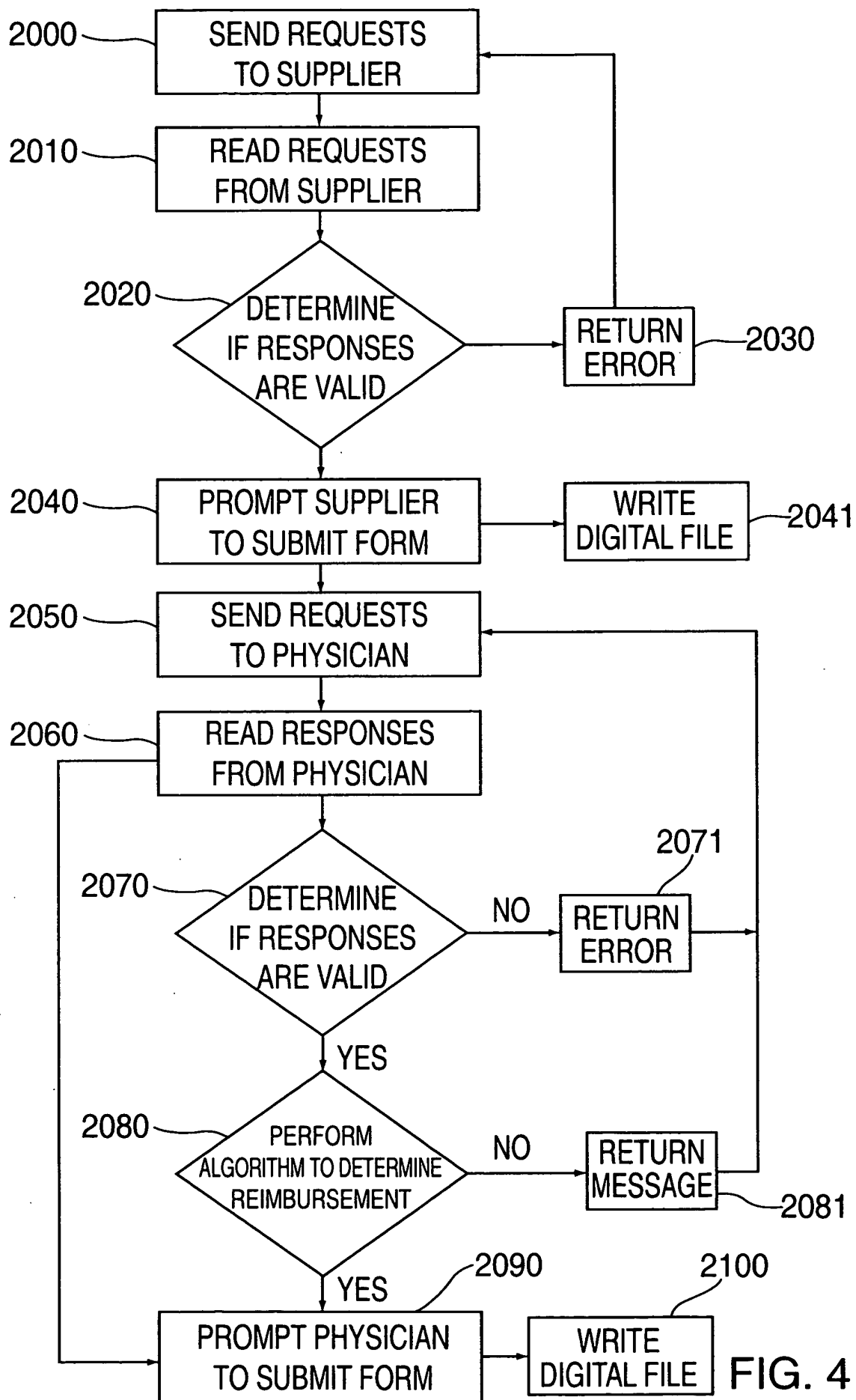


FIG. 4

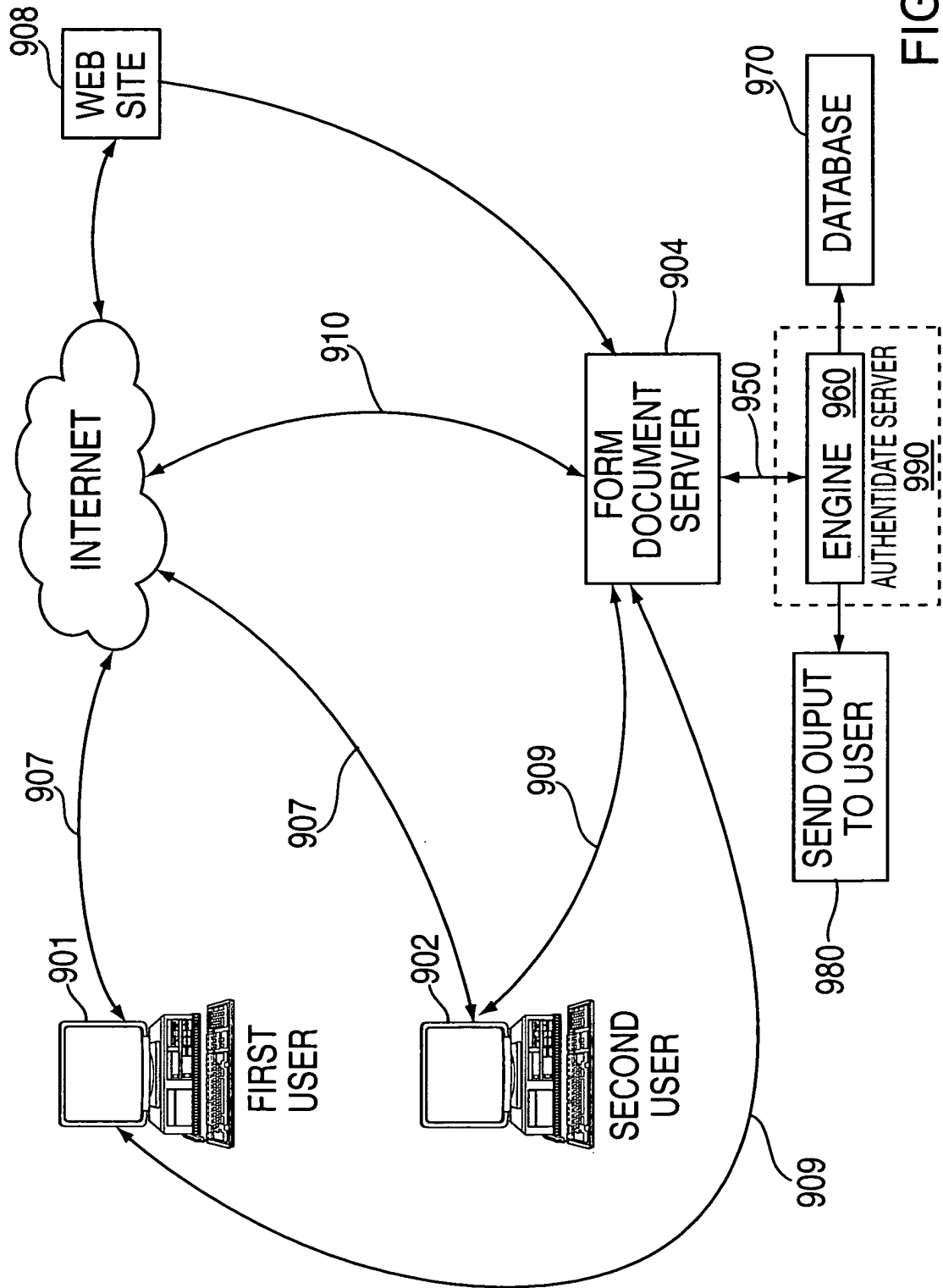


FIG. 5

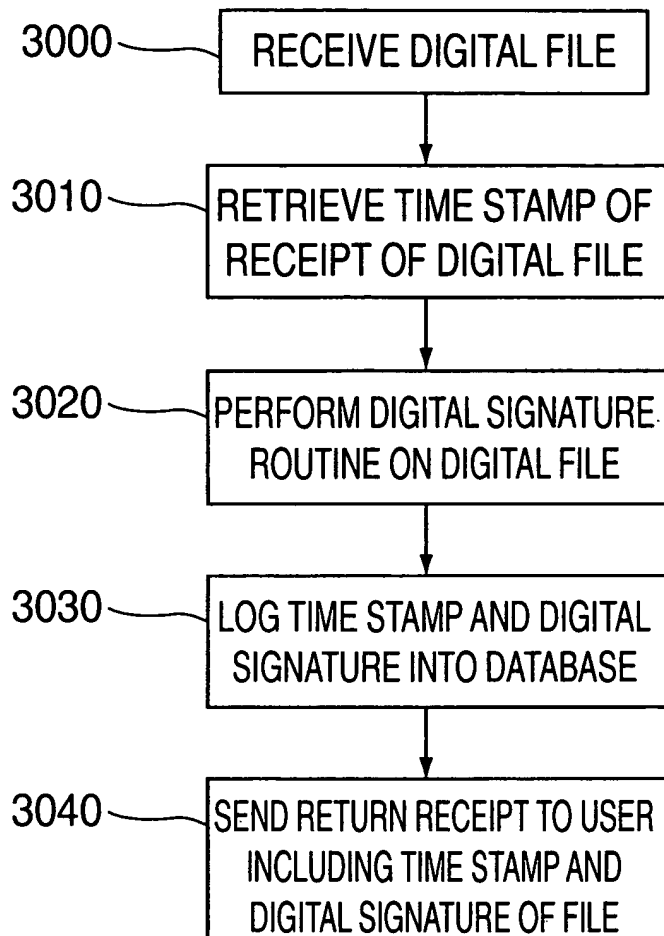


FIG. 6

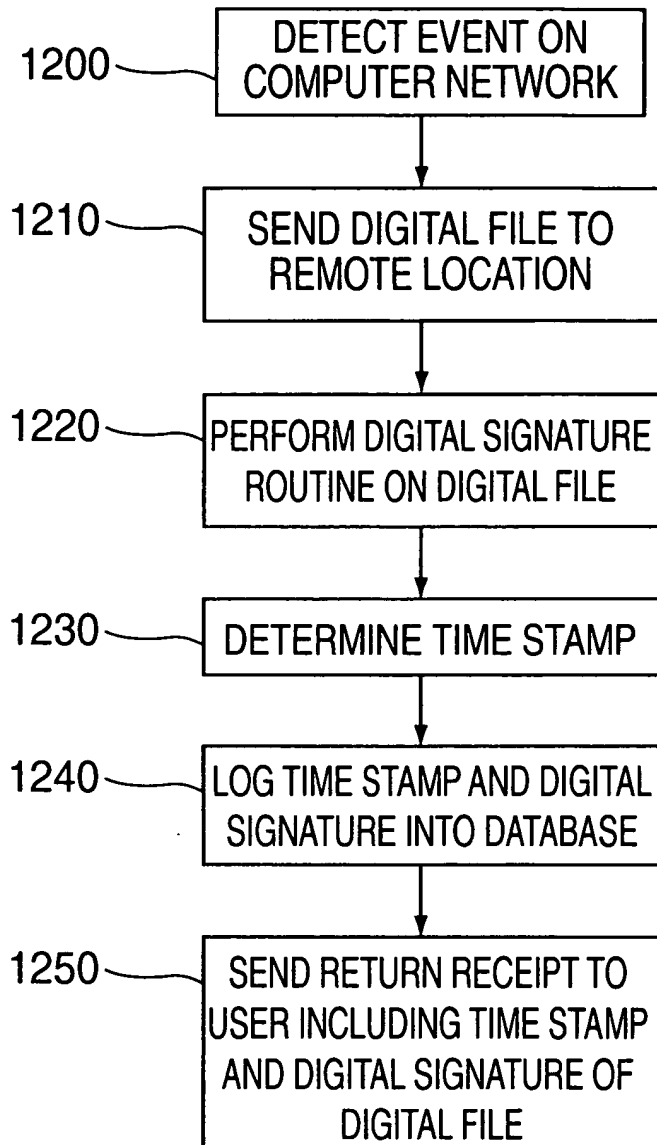


FIG. 7